

# Colgate Swim Camp

Due back by: June 15, 2018

(Send the original – and also bring a copy to camp)

**PLEASE COMPLETE ENTIRE FORM!**

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

Student Name (print) \_\_\_\_\_

Age at camp \_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Gender: M F

Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number (Day): ( \_\_\_\_\_ ) \_\_\_\_\_

(Eve): ( \_\_\_\_\_ ) \_\_\_\_\_

In Case of Emergency and parent / guardian **cannot** be reached:

Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

**Parent/Guardian Authorizations:** This health history is correct and complete. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to YOUR CAMP to provide routine healthcare and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the Camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the Director of YOUR CAMP or their designee to secure and administer treatment, including hospitalization, for the student named above.

**Indemnification:** The undersigned parent/guardian of the registrant, for and in further consideration of YOUR CAMP and Colgate University's accepting said registrant, hereby agrees to save and indemnify and keep harmless the said YOUR CAMP and Colgate University, the individual members, employees, staff, faculty, agents, representatives, and officers from and against any claims, judgments, or demands which I, any other parent or guardian, the student, or any other person might make for any losses, damages, personal, mental, or physical injuries against any and all liability, arising as a result of any course of instruction or activity given the registrant by YOUR CAMP or Colgate University. This release and assumption of risk shall bind myself, my heirs, my assigns, and my personal representatives.

*Signature of Parent/Guardian* \_\_\_\_\_

*Printed Name* \_\_\_\_\_ *Date* \_\_\_\_\_

**Medical Insurance Company (REQUIRED)**

Ins. Co. \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insured Employer \_\_\_\_\_

*We recommend that a photocopy (front and back) of health insurance card be attached to this form.*

## Health History:

<i>Check those that apply:</i>	<i>Life Threatening Conditions</i>
<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Ear Aches / Infection
<input type="checkbox"/> Gyn Problems	<input type="checkbox"/> Poison Ivy, Oak, Sumac
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Absence of a paired organ
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Current orthodontic appliance	<input type="checkbox"/> Mononucleosis in the past 12 months
<input type="checkbox"/> Skin Problems (Acne, Eczema)	<input type="checkbox"/> Recent Illness / Infections
<input type="checkbox"/> HBP	<input type="checkbox"/> Concussion / Head Injury
<input type="checkbox"/> Bone / Joint Injuries	<input type="checkbox"/> Other Chronic Condition
<input type="checkbox"/> Operations	<input type="checkbox"/> Other

\*\*\* Details of above to be completed on additional sheet \*\*\*

**Individualized Order Form** for ALL medications **MUST** also be completed.  
This form is available on the backside of this page!

Immunization and Physical form from school / physician may be submitted in lieu of completing the immunization and physical examination section below.

## Immunizations

<i>Immunizations</i>	<i>Date</i>	<i>Boosters</i>
Dtap/TD/Tdap		
Polio (3)		
Hepatitis B (3)		
MMR (2)		
TD (valid 10 y)		
Haemophilus Influenza Type B		

<i>Immunizations or proof of illness</i>	<i>Date</i>
Varicela or proof of Chicken Pox	

<i>Illness (if applicable)</i>	<i>Date</i>
Measles	
German measles	
Mumps	
Hepatitis A	
Hepatitis C	

**Physical Examination: - Valid for One Year Only and to Be Completed by a Licensed Health Care Professional ONLY!**

Height	Weight
Hearing (R / L)	Vision (R / L)
Dental / Bite	Respiratory
Cardiac	BP
Hernia	Extremities
Genitals	Skin

**RESTRICTIONS, LIMITATIONS (INCLUDING DIET):**

## RECOMMENDATIONS:

The above named person is in satisfactory condition and may engage in all camp activities except as noted:

Date: \_\_\_\_\_ Examining physician: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_

Print physician's name: \_\_\_\_\_

State licensed in: \_\_\_\_\_ License #: \_\_\_\_\_

Address: \_\_\_\_\_

*Please mail original by June 15, 2018 (IMPORTANT) and also bring one copy to camp:*  
Colgate Swim Camp  
13 Oak Drive, Hamilton NY 13346  
Tel. 315-228-7614  
**\*\* PLEASE SEE REVERSE SIDE \*\***

# Individualized Order Form

**CAMPER:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ lbs.

The following form must be completed and signed by the child's physician if your child:

- Needs to take any routine Over the Counter Medications, provided by the parent/guardian, while at camp.
- Needs to take any routine Prescription Medications, provided by the parent /guardian, while at camp.

If your child needs to take any "as needed" over-the-counter medications while at camp, he or she will need to see a medical professional for a prescription.

## All Medications (Prescription and Over-the-Counter)

Please complete with the camper's current regimen for both **Prescription and Over-the-Counter** medications (i.e. antibiotics, asthma inhalers, allergies, etc.).

**This person takes NO medications on a routine basis.**

Drug Name	Route	Dosage	Physician Order / Regimen	Comments

**The following information to be completed by the camper's health care provider:**

Camper's Health Care Provider Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ License #: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian's Signature: \_\_\_\_\_ Date : \_\_\_\_\_